



Simplifying ACO Quality Reporting:

A Practical Guide to Making the Shift to eCQMs, MIPS CQMs, and Medicare CQMs

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Agenda

- About the APM Performance Pathway (APP)
- Five Steps to Report the APP
- Q and A

About MDinteractive

- Disease management registry for over 20 years
- CMS Qualified Registry since 2010
- Submitted CMS quality measures (eCQMs and CQMs) for thousands of clinicians

About MDinteractive

- ONC and SOC II Certified and FHIR ready
- Known for our exceptional support and low prices
- **Tools, technology, and support dedicated to CMS Quality programs**

About the APP

Per CMS, in 2025, Medicare Shared Savings Program (MSSP) ACOs must report:

- 3 Quality Measures
- All ACO Participants
- All Payors

APP Measures

- 1. Diabetes Mellitus: Hemoglobin A1c Poor Control**
 - 2023 eCQM: CMS122 v11
 - 2023 MIPS CQM: #1
- 2. Screening for Depression and Follow-up Plan**
 - 2023 eCQM: CMS2 v12
 - 2023 MIPS CQM: #134
- 3. Hypertension (HTN): Controlling High Blood Pressure**
 - 2023 eCQM: CMS165 v11
 - 2023 MIPS CQM: #236

2024 APP Options

Collection types	eCQMS	MIPS CQMs	Medicare CQMs, Proposed
ACO Participants	All	All	PCPs and specialist with one of the designated specialties
Payors	All	All	Medicare Fee-for-Service
ACO Quality Performance Standard (2024)	10th percentile on 1 outcome measure and 40th percentile on other measure or 40th percentile across all MIPS quality performance category scores	10th percentile on 1 outcome measure and 40th percentile on other measure or 40th percentile across all MIPS quality performance category scores	40th percentile across all MIPS quality performance category scores
Benchmarks (2024/2025)	Historical	Historical	To be calculated by CMS after all submission period
Data Completeness	100%	75%	75%
Data sources	QRDA, FHIR	QRDA, FHIR, billing files, patient lists	QRDA, FHIR, billing files, patient lists

Considerations: Web Interface and APP in 2024

ACO Considerations

~180,000
patients
eligible for
depression
screening

Groups/TINs
76
NPIs: 2032

~90,000
patients with
hypertension

Multiple
EHRs
30

Paper
10

~35,000
patients with
diabetes

Five Steps To Report the APP

1. Conduct data platform inventory.
2. Collect measure data.
3. Deduplicate and aggregate data.
4. Review metrics.
5. Connect with FHIR.

Step 1:

Conduct data platform
inventory.



Data Platform Inventory

1. Identify EHRs and functionality.
2. Identify practices on paper.

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15.04.04.2700.Apri.19.01.1.221228	2015 Cures Update	CompuGroup Medical US	CGM APRIMA	v19	Dec 28, 2022	✓



Right Measures. Right Versions. eCQM Reporting



Version	Quality Measure	170.315 (c)(1)	170.315 (c)(2)	170.315 (c)(3)	170.315 (c)(4)
v12	CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	✓	✓	✓	✓
v11	CMS122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	✓	✓	✓	✓
v11	CMS165: Controlling High Blood Pressure	✓	✓	✓	✓

Missing Measures - CQM Reporting



Version	Quality Measure	170.315 (c)(1)	170.315 (c)(2)	170.315 (c)(3)	170.315 (c)(4)
v7	CMS68: Documentation of Current Medications in the Medical Record	✓	⊘	⊘	⊘
v6	CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	✓	⊘	⊘	⊘
v6	CMS127: Pneumococcal Vaccination Status for Older Adults	✓	⊘	⊘	⊘
v7	CMS129: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	✓	⊘	⊘	⊘
v6	CMS130: Colorectal Cancer Screening	✓	⊘	⊘	⊘
v6	CMS134: Diabetes: Medical Attention for Nephropathy	✓	⊘	⊘	⊘
v6	CMS138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	✓	⊘	⊘	⊘
v6	CMS156: Use of High-Risk Medications in the Elderly	✓	⊘	⊘	⊘
v6	CMS164: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	✓	⊘	⊘	⊘
v6	CMS165: Controlling High Blood Pressure	✓	⊘	⊘	⊘
v7	CMS166: Use of Imaging Studies for Low Back Pain	✓	⊘	⊘	⊘

Data Platform Inventory

Recap

- Collecting information about all ACO data platforms essential starting point
- Use CHPL site to assess EHR functionality
- Check CEHRT, check measures, check versions

Step 2:

Collect Measure Data.



Get Data

From All ACO Participants

1. Collect EHR files for 3 APP measures from practices with required functionality.
2. Collect billing reports or patient lists from practices without required EHR functionality.

Billing Files / Patient Lists for Practices on Paper

- Provide templates for the measures with data points needed
- Work with practice to efficiently collect what's needed

2 Types of EHR Quality Files

- **QRDA III:**
 - Summary performance data for measures
 - Single small .xml file
- **QRDA I:**
 - Patient level data
 - Many .xml files, usually packed together into a large .zip file

QRDA I files are needed for APP

QRDA I Module

Export Quality Data



Select file format for export - Required



- QRDA-I (Patient level file as .ZIP)
- QRDA-III (Aggregate quality report as .XML)
- Patient level details as .CSV
- Measure performance total as .CSV

Cancel

Export

QRDA I Files

Considerations

- Some practices need to upgrade their EHR to access that functionality
- Generating QRDA I files can be time-consuming
- Missing data (TIN, NPI, and other fields) can impact file generation and processing
- All patients listed with “Payer Other” *

***Additional data needed to report Medicare CQMs**

QRDA I File Generation Problem

Case Study

Challenge: GI Practice repeatedly generated QRDA III files instead of QRDA I.

Action: MDinteractive explained file types and finally suggested EHR support ticket.

Root Case Identified: Missing ethnicity and race data.

Solution: Practice completed fields / generated QRDA I file.

Data Collection Recap

- ACO participant education needed to facilitate compliance
- QRDA I files are unfamiliar to most practices
- Guidance, troubleshooting, and collaboration needed
- Knowledge and advanced planning critical

Step 3:

Deduplicate and aggregate data.



Requirements

- Patients must be represented **only once** in aggregated ACO metrics
- **Demographic and medical** information matched to combine multiple records
- Approach must be measure specific

De-Duplication / Aggregation Example for Blood Pressure

Practice	EHR Name	First	Last	DOB	Visit Date	Value	Status
1	EPIC	Mary	Jones	2/4/49	1/13/23	170/90	Not Met
2	eCW	Mary	Jones	2/4/49	4/20/23	135/85	Met
3	Allscripts	Mary	Jones	2/4/49	6/10/23	150/95	Not Met
4	Practice Fusion	Mary	Jones	2/4/49	9/2/23	130/75	Met
ACO	N/A	Mary	Jones	2/4/49	9/2/23	130/75	Met

Step 4:

Review metrics.



Review Metrics

Review data at ACO, TIN / Practice, Clinician, and Patient Level:

- Ensure that it meets CMS requirements
- Ensure that it “makes sense”
- Identify improvement opportunities

CMS Data Requirements

- 100% of patients eligible for 3 APP measures identified
- Completeness rate is at least 75% (2024) for CQM and 100% for eCQM
- Performance rate for 3 measures meets shared savings requirements

Does it Make Sense?

- **Typically for ACO and TIN* Level Metrics:**
 - **CMS2 > CMS165 > CMS122**
 - Eligible patients for depression screening
 - > eligible patients with hypertension
 - > eligible patients with diabetes

*exceptions exist

ACO Data

ID	Measure	Measure Type	Priority	To
1 View/Edit patients	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (more info)	OUTCOME	YES	
134 View/Edit patients	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (more info)	NOT OUTCOME	NO	
236 View/Edit patients	Controlling High Blood Pressure (more info)	OUTCOME	YES	

Benchmarks:

1 Points 1.00 - 9.99
 2 Points 10.00 - 19.99
 3 Points 20.00 - 29.99
 4 Points 30.00 - 39.99
 5 Points 40.00 - 49.99
 6 Points 50.00 - 59.99
 7 Points 60.00 - 69.99
 8 Points 70.00 - 79.99
 9 Points 80.00 - 89.99
 10 Points >= >= 90.00

Registry benchmark

Percentiles:

1 >= 1
 10 >= 10
 20 >= 20
 30 >= 30
 40 >= 40
 50 >= 50
 60 >= 60
 70 >= 70
 80 >= 80
 90 >= 90
 99 >= 99

Registry percentiles

Option	Num Den - Exc	Performance	Reporting Rate	Points
Registry	2000 10000 - 0	20.00% (41.31%)	100.00% (10000)	9 Pts ? (Picked at 1)
Registry	40000 100000 - 0	40.00% (12.53%)	100.00% (100000)	2.2804 Pts ? (Picked at 3)
Registry	20000 30000 - 0	66.67% (51.81%)	100.00% (30000)	7.6667 Pts ? (Picked at 2)

**TIN, NPI, and
Patient Level
Available**

Data from a Surgeon Case Study

> Preventive Care and Screening: Screening for Depression and Follow-Up Plan



0 / 481

> Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) INVERSE MEASURE ⓘ



0 / 0

> Controlling High Blood Pressure



0 / 0

- 481 patients eligible for depression screening with 0% performance
- No patients eligible for A1c or Blood Pressure control
- Meets technical requirements

Data from a PCP Case Study

Measure	Measure Type	Priority	Topped Out	Reporting Period	Option	Num	Performance	Reporting Rate	Points
						Den - Exc			
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (more info)	OUTCOME	YES	NO	2023-01-01 ↓ 2023-12-31	EHR ETE	54 <hr/> 55 - 0	98.18% (41.31%)	100.00% (55)	1.2162 Pts ? (Picked at 3)
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (more info)	NOT OUTCOME	NO	YES	2023-01-01 ↓ 2023-12-31	EHR ETE	30 <hr/> 329 - 0	9.12% (12.53%)	100.00% (329)	3.2407 Pts ? (Picked at 2)
Controlling High Blood Pressure (more info)	OUTCOME	YES	NO	2023-01-01 ↓ 2023-12-31	EHR ETE	177 <hr/> 219 - 0	80.82% (51.81%)	100.00% (219)	9.913 Pts ? (Picked at 1)

- Eligible patients for all measures
- Low performance on Diabetes and Depression
- Meets technical requirements

Metric Review Recap

- Review data to ensure
 - compliance with CMS rules
 - that it “makes sense”
- Drilldown to highlight opportunities
- Prioritize improvement activities based on impact

Step 5:

Connect with FHIR!



What is FHIR?

- [FHIR® \(Fast Healthcare Interoperability Resources\)](#)
- EHR data exchange through standards-based APIs
- **Cures Update mandates FHIR for all EHRs**
- CHPL site depicts FHIR readiness with this entry:

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✓ 170.315 (g)(10) Standardized API for Patient and Population Services (Cures Update)

Why FHIR for APP?

- Ongoing data updates
- Less manual work
- Can improve performance picture
- Access free for most EHRs
- CMS plans to transition to Digital Quality Measures (dQMs) for quality reporting using FHIR

How to Set Up FHIR Practice Authorizes Access

First name - Required

Last name - Required

Title/Position - Required

Email - Required

Phone number - Required

Practice name - Required

Practice ID - Required

By clicking "I consent " below you agree that you are duly authorized by all necessary corporate action of Client to submit this authorization and consent form, and this will constitute the legal, valid, and binding authorization and consent of Client.

Types of FHIR Access

- **Patient-Level Access:**
 - Allows specific data queries for individual patients
 - Like accessing your own medical chart online
- **Population-Level / Bulk FHIR Access:**
 - For exchanging large data sets
 - Patient names not needed

Patient-Level FHIR

Case Study

- **Objective:** Check A1c values for ~35,000 ACO diabetes patients
- **Runtime:** ~5 hours
- **Steps:**
 - Download entire ACO diabetes population from registry
 - Sequentially interrogate the FHIR API to retrieve individual patient lab observations.
- **Results:**
 - ~5000 patients found to have new A1c labs
 - **Updated labs improved performance rate by 5 points!**

Population-Level (Bulk) FHIR Case Study

- **Objective:** Identify the eligible patients from a practice for the 3 APP quality measures
- **Runtime:** ~3 days
- **Steps:**
 - Define Bulk/Population criteria: all patients with an encounter after 1/1/2023
 - Generate and download ndjson FHIR files:
 - Patient: 1623 records
 - Observation: 62107 records
 - Condition: 205290 records
 - Encounter: 35245 records
 - Practitioner: 2064 records
 - Process and analyze FHIR files (runtime: ~5 minutes)
- **Results:**
 - Diabetes: 146 patients
 - Hypertension: 636 patients
 - Depression screening: 933 patients

FHIR and Artificial Intelligence with Unstructured Data

Case Study

- **Objective:** Find depression screening results for a practice by utilizing unstructured free text in EHR medical progress notes
- **Runtime:** 4.5 hours
- **Steps:**
 - Download 2188 medical progress notes
 - Remove Personally Identifiable Information (PII)
 - Search for PHQ-2 and PHQ-9 results
 - If screen positive for depression use AI analysis to distinguish between:
 - Positive screen, follow-up plan documented
 - Positive screen, follow-up plan not done
- **Results:**
 - Updated depression screening performance rate by 18 points!

FHIR Recap

- All Cures Updated EHRs have FHIR available
- FHIR can:
 - keep data current
 - lessen need for manual collection
 - combined with AI can capture data from “hard to reach places”
 - improve performance picture
- Important strategic consideration with the APP as CMS will eventually use it to replace eCQM reporting

Let's Wrap It Up!



Five Steps To Report the APP

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easy

Questions?



Thank you for Attending!



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